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 prévue 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
Feb 19, 2019	2018_560632_0025	028816-17, 010908-18, 011225-18, 011626-18, 012224-18, 013768-18, 018160-18, 025697-18	Complaint

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Waterford Long Term Care Residence
2140 Baronwood Drive OAKVILLE ON L6M 4V6

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

YULIYA FEDOTOVA (632), DIANNE BARSEVICH (581), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 18, 19, 20, 21, 24, 31, 2018 and January 2, 3, 4, 7, 2019.

The following intakes were completed in this Complaint inspection:

Log #028816-17 and 013768-18 were related to prevention of abuse and neglect.
Log #010908-18 and 011626-18 were related to falls prevention, medications.
Log #011225-18 was related to nutrition and hydration, personal support services.
Log #018160-18 was related to personal support services, sufficient staffing.
Log #025697-18 was related to medications.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care 1, the Co-Director of Care 2, Assistant of the Director of Care, the Residents Assessment Instrument (RAI) Co-ordinator, the Unit Clerk, the Registered Dietitian, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), residents and their families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 VPC(s)**
- **1 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. 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).

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 failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A complaint (log #025697-18) was received by the Ministry of Health and Long-Term Care (MOHLTC) that resident #005 was administered a specified medication. The medication was not prescribed for the resident. The resident had a specified device in place and no history of using specified medication.

The home's Report and Analysis Form, dated on an identified date in August 2018, was reviewed. It was noted that, on an identified date in August 2018, a personal support worker reported to the registered staff that resident #005 had received a specified medication. The resident had no medical order for the administration of the medication. The resident's vital signs were assessed. The physician on call was notified and they gave an order for the resident's vital signs to be monitored every shift for an identified period of time. The resident's Substitute Decision Maker (SDM) and the DOC were also notified of the incident. There was no harm to the resident and monitoring/intervention was required. No causes of the incident or contributing factors were identified on the incident report.

The home's incident investigation record was reviewed and indicated information as above.

The resident's health record including the Interdisciplinary Care Conference record, dated in November 2018, was reviewed and it was noted the resident had received a medication that had not been prescribed. The home did an investigation but could not determine who administered the specified medication.

The home failed to ensure that no drug was used by or administered to resident #005 in the home unless the drug had been prescribed for the resident.

Please note: this non-compliance was issued as a result of Complaint log #025697-18, which was included in this inspection. [s. 131. (1)]

2. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A. A complaint (log #025697-18) was received by the MOHLTC that resident #005 did not receive a specified medication as ordered. The resident was to receive the medication at identified frequency. The resident received an additional doze of the prescribed medication.

The home's investigative records and the health record of resident #005 including the specified Report were reviewed. It was noted that in November 2017, specified medication was administered to resident #005 not as ordered. The resident's SDM, the pharmacy service provider, the attending physician, the DOC and the Medical Director were notified of the incident. There was no harm to the resident as a result of the incident. Educational support was provided to the staff.

DOC #100 was interviewed and reported information as documented above. They also reported that the physician made a temporary change to the prescribed medication order. DOC #100 confirmed that, on an identified date in November 2017, the medication was not administered to resident #005 in accordance with the directions for use specified by the prescriber.

The home failed to ensure that drugs were administered to resident #005 in accordance with the directions for use specified by the prescriber.

Please note: this non-compliance was issued as a result of Complaint log #025697-18, which was included in this inspection.

B. The home's records for a specified three month period in 2018 were reviewed.

It was noted that, on an identified date in November 2018, staff #128 discovered a medication error involving resident #012. The resident received a specified dose of the

medication not as prescribed. The resident/POA, pharmacy service provider, attending physician, DOC, Prescriber and RN EC were notified. The resident was monitored and had no harm as a result of the incident.

The DOC was interviewed and confirmed drugs were not administered to resident #012 in accordance with the directions for use specified by the prescriber.

The home failed to ensure that drugs were administered to resident #012 in accordance with the directions for use specified by the prescriber.

Please note: this non-compliance was issued as a result of Complaint log #025697-18, which was included in this inspection.

C. The home's medication incident records for a specified three month period in 2018, were reviewed.

Resident #009 was ordered specified medication. It was noted that, on an identified date in December 2018, registered staff #131 discovered that the strength of the medication administered to resident #009 was not the same as ordered. As a result, the resident received identified doses of the incorrect strength of the medication. The resident/SDM, physician on-call, DOC #102 and the pharmacy service provider were notified of the incident. The physician was informed and ordered a temporary change in the medication. There was no harm to the resident as a result of the incident.
Registered staff #130 who was involved in the incident, was interviewed and confirmed the information in the home's record.
DOC #100 confirmed drugs were not administered to resident #009 in accordance with the directions for use specified by the prescriber as noted above.

The home failed to ensure that drugs were administered to resident #009 in accordance with the directions for use specified by the prescriber.

Please note: this non-compliance was issued as a result of Complaint log #025697-18, which was included in this inspection. [s. 131. (2)]

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. 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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system that the plan, policy, protocol, procedure, strategy or system was complied with.

The licensee failed to ensure policies included in the required Falls Prevention and Management program were complied with.

In accordance with O. Reg. 79/10, s. 48(1) 1 the licensee is required to have an interdisciplinary Fall Prevention and Management program and in accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is required to ensure that each of the required programs includes policies, procedures and protocols.

The licensee's policy "Head Injury Routine" (HIR) identified as policy number LTC-CA-WQ-200-07-04, last revised in December 2017, included as part of the licensee's Falls Prevention and Management program, directed that "any resident who may of sustained an injury to their head as a result of a fall or other such incident where the resident's head may have come in contact with a hard surface will have a head injury routine initiated." Once initiated the HIR will continue for 48 hours unless it was ordered to

discontinue by the physician or nurse practitioner. "Head injury is performed every 15 minutes for the first hour, then every 30 minutes for the next two hours (total of three hours post fall), then every hour for the next four hours (total of seven hours post fall), then every four hours until 72 hours post fall has been reached."

A review of Complaint inspection log #011626-18, identified that in June 2018, resident #001 had a fall that resulted in injury.

A review of the specified record for resident #001 identified that registered staff initiated HIR post fall but did not complete the HIR every 15 minutes for the first hour. In an interview with ADOC #107 in December 2018, they confirmed that the HIR was not completed every 15 minutes for the first hour post fall.

The licensee's HIR policy for the fall in June 2018, for resident #001 was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with.
In accordance with O. Reg. 79/10. s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The home's specified policy and procedure #LTC-CA-WQ-200-06-03, revised in 2017, was reviewed and included that specific instructions related to the administration of specified medications.

A. A complaint (log #025697-18) was received by the MOHLTC that resident #005 was administered specified medication though they were not prescribed that medication. The resident had no history of using the medication. The medication was administered to the resident during specified period of time.

i. The home's investigative records were reviewed. The Medication Incidents Report and Analysis Form indicated that on that date a PSW reported to the registered staff that resident #005 had specified medication administered. The resident had no order for the administration of the medication. The resident's vital signs were assessed. The

physician on-call was notified and they gave an order for the resident's vital signs to be monitored at identified frequency. The resident's SDM and the DOC were also notified of the incident. The resident was monitored and there was no harm to the resident. No causes of the incident or contributing factors were identified on the incident report form.

DOC #102 reported information as contained in the home's investigative records and the residents' records. They verified the accuracy of the information in the above records. Registered staff #112 reported that they did not follow the specified policy. Registered staff #112 was provided education related to the home's policy and procedure related to administering specified medications by DOC #102.

Registered staff #112 was interviewed on an identified date in January 2019. They denied having detailed memory of the incident involving the discovery of the medication. They remembered that the DOC #102 interviewed them about the incident and they signed and dated the statement.

The statement of registered staff #112 was included in the home's investigation record and it was reviewed with staff #112. They confirmed the accuracy of the information in the home's investigation record as noted in the written statement. Registered staff #112 reported that when they were interviewed by the DOC #102, related to the specified incident, they informed DOC #102 that they did not comply with the homes policy and that the DOC had re-instructed them on appropriate actions to take.

The home failed to ensure that the home's medication policy and procedure were complied with.

Please note: this non-compliance was issued in relation to Complaint log #025697-18, which was included in this inspection.

ii. The written statement, dated in August 2018 and initialed by registered staff #129, was reviewed and indicated that, in August 2018, registered staff #129 administered medication to resident #010. They failed to comply with the home's policy related to the specified medication. Registered staff was interviewed and confirmed the accuracy of the information in their statement provided in the home's medication incident record.

The home failed to ensure that the home's specified policy and procedure were complied with.

Please note: this non-compliance was issued in relation to Complaint log #025697-18, which was included in this inspection.

iii. The home's specified policy and procedure #LTC-CA-WQ-200-06-03, revised in December 2017, was reviewed and included that prior to providing the specified medication to the resident, staff were to take specific actions.
The home's records of resident #012 were reviewed and indicated that, on an identified date in November 2018, staff #128 identified that the policy had not been complied with in relation to resident #012. DOC #100 confirmed the accuracy of the information in the above records.

Registered staff #138, who was involved in the incident was interviewed and confirmed they did not follow the home's specified policy and procedure.

The home failed to ensure the home's specified policy and procedure were complied with.

Please note: this non-compliance was issued in relation to Complaint log #025697-18, which was included in this inspection.

B. The home's Medication Administration policy and procedure #LTC-CA-WQ-200-06-01, revised in 2017, was reviewed and included that the registered staff would confirm the medications for administration at the time of the medication pass.

The home's medication incidents for a specified three month period in 2018 were reviewed including the Medication Incident Report and Analysis Form dated in December 2018. It was noted that resident #009 received a dose of medication that was not prescribed for them. The nurses did not check the medications in the packages as per the home's medication policy and procedure.

The Occurrence Note was reviewed and contained information as above.

DOC #100 and registered staff #130 were interviewed and reported information as in the home's incident investigation records and the resident's records. They confirmed the home's medication administration policy and procedure was not followed as above.

The home failed to ensure that the home's Medication Administration policy and procedure was complied with.

Please note: this non-compliance was issued in relation to Complaint log #025697-18, which was included in this inspection. [s. 8. (1) (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 and ensuring that 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 that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. A complaint log #011225-18 (IL-57150-HA) was submitted to the MOHLTC in May 2018, indicating that the needs of resident #002 were not met. Review of the resident's written plan of care indicated that resident #002 was at nutrition risk and required specified interventions. Review of the current Documentation Survey Report v2 records for November and December 2018 indicated that documentation in eating task, on five specified days in November and December 2018, were not completed. PSW #114 and PSW #118 indicated that the resident had their meals and required support for the

resident was provided during meals but it was not documented.

Review of the current Documentation Survey Report v2 for December 2018 indicated that documentation in bathing task section on three specified dates in 2018 and in personal hygiene section on five specified dates in 2018 were not completed. Review of the resident's written plan of care indicated that the resident required assistance for bathing and with their personal hygiene. PSW #113 and PSW #114 indicated that required assistance with the personal hygiene and for bathing for resident #002 was provided but not documented.

On January 3, 2018, DOC #100 indicated that a refresher training was provided for PSW staff in 2018 about the documentation of care and it was the home's expectation that PSW would document it in the Point of Care (POC), once the care was provided to the resident.

The home did not ensure that interventions during meal, personal hygiene and bathing activities and resident #002's responses to these interventions were documented.

Please note: this non-compliance was issued as a result of Complaint log #011225-18.

B. A complaint log #018160-18 (IL-58172-HA) was submitted to the MOHLTC in July 2018, indicating resident #004 was not provided grooming and bathing twice weekly during summer 2018. Review of resident #004's written plan of care indicated that resident #004 required care with bathing. Review of Documentation Survey Report v2 for a period of June - August 2018 indicated no documentation on three specified dates in 2018. PSW #105, PSW #106 and PSW #108 indicated that the care for bathing for resident #004 was provided but was not documented.

Review of resident #004's written plan of care indicated that resident required assistance with personal hygiene. Review of Documentation Survey Report v2 for a period of June to August and for December 2018, indicated that no documentation for personal hygiene care was completed. Five PSWs interviewed and indicated the care with personal hygiene was provided but not documented.

Review of resident #004's written plan of care indicated that resident #004 required assistance with eating. Review of Documentation Survey Report v2 for December 2018, indicated on specified date in 2018 documentation in eating task was not completed.

PSW #120 indicated the assistance with eating was provided for resident #004 but not documented.

In January 2018, DOC #100 indicated that a refresher training was provided for PSW staff in 2018, about the documentation of care and it was the home's expectation that PSW would document it in POC, once the care was provided to the resident.

The home did not ensure that interventions during meal, personal hygiene and bathing activities and resident #004's responses to these interventions were documented.

Please note: this non-compliance was issued as a result of Complaint log #018160-18.

C. Review of resident #005's written plan care indicated that the resident required assistance with bathing and with their personal hygiene. Review Documentation Survey Report 2 record for December 2018 indicated that documentation on bathing and personal hygiene tasks on three specified dates in 2018 were not completed for resident #005. PSW #116 and PSW #117 indicated that the required assistance from the staff with bathing and personal hygiene for resident #005 was provided but was not documented.

On January 3, 2018, DOC #100 indicated that a refresher training was provided for PSW staff in 2018 about the documentation of care and it was the home's expectation that PSW would document it in POC, once the care was provided to the resident.

The home did not ensure that interventions during personal hygiene and bathing activities and resident #005's responses to these interventions were documented. [s. 30. (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 and ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A review of Complaint intake log #011626-18 submitted in June 2018, identified concerns regarding falls prevention and management for resident #001.

Review of clinical health record identified that resident #001 fell and sustained an injury. Review of the specified information about the fall by MOHLTC Inspector identified the resident was transferred manually by RN #109 and PSW #110.

Review of the home's policy "Mechanical Lifts and Resident Transfers" policy no: LTC-CA-WQ-200-07-12, revised in December 2017, identified that "manual lifting means moving a resident who cannot weight bear or physically assist without the use of a mechanical lift device." This was contrary to this policy. "No lift means there are no manual resident lifts permitted (therefore there are no resident lifts or transfers physically done by the worker or workers)."

During an interview with PSW #110 and RN #109 they both confirmed they manually transferred resident #001 after the resident had fallen.

Review of a specified form identified that RN #109 and PSW #110 manually transferred the resident and they failed to follow the proper procedures and policy on lift and transfers.

During an interview with DOC #100 they stated that all residents that had fallen were to be transferred using mechanical lifts and the licensee had no lift policy for all staff in place related to transfers.

DOC #100 confirmed that RN #109 and PSW #110 failed to use safe transferring devices and techniques, when resident #001 was transferred without a mechanical lift. [s. 36.]

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 and ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of Complaint intake log #011626-18 submitted in June 2018, identified concerns regarding falls prevention and management for resident #001.

Review of the clinical health record identified that resident #001 had a fall that resulted in injury. Information about the fall was reviewed by MOHLTC Homes Inspector, which identified the resident was transferred manually by RN #109 and PSW #110 and post-fall assessment was not initiated or completed prior to the resident being transferred.

Review of a specified form identified that the RN failed to follow the required steps for resident falls including comprehensive assessments in a timely manner.

During an interview with the RN they confirmed they did not assess the resident prior transferring them and stated they completed the post-fall assessment over one hour later. In an interview with DOC #100 they stated that the post-fall assessment was to be completed post-fall and that all residents, who had fallen, were to be assessed prior to being moved or transferred to ensure there were no injuries and that it was safe to move the resident.

DOC #100 confirmed that, when resident #001 had fallen, a post-fall assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for falls before the resident was transferred. [s. 49. (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 and ensuring that when the resident have fallen, the resident is assessed and that where the condition or circumstances of the resident required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #6: 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 failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(b) reported to the resident, the resident's SDM, 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.

The MOHLTC received a complaint related to medication incidents.

The home's medication incidents for the specified three months period in 2018 were

reviewed.

A. The home's investigation record including the Medication Incident Report was reviewed and it was noted that a medication incident had occurred involving resident #012. The resident/SDM, on-call physician, DOC were noted to have been informed of the incident. The Medical Director was not noted to have been notified of the incident. The resident's health record was reviewed and it contained no information related to the Medical Director being notified of the incident.
DOC #102 was interviewed and reported the home notifies the attending and or the on-call physicians of the incidents. The Medical Director was informed at the Professional Advisory Meeting where the incidents were reviewed.

B. The home's Medication Incidents for a specified three months period in 2018 were reviewed. The home's incident investigation records were reviewed. It was noted that resident #009 was involved in a medication incident. There was no harm to the resident as a result of the incident. The Medical Director was not noted to have been informed.

The home's comparison of medication incidents for three quarters; the analysis and trend report the Action Plan for medication management documents and the 2018 Medication Management program evaluation provided by DOC #102 were reviewed.
DOC #100 reported the home did not notify the Medical Director of each medication incident. The staff notified the attending/on-call physicians of the incidents. The Medical Director was informed of medication incidents quarterly at the Professional Advisory (PAC) Meeting, where a summary of medication incidents was discussed/reviewed. They also confirmed that the Medical Director had not yet been informed of the above medication incidents. They would be notified at the Annual PAC meeting.

The home failed to ensure that every medication incident involving resident #012 and every adverse drug reaction was, reported to the Medical Director.

This non-compliance was issued in relation to Complaint log #025697-18, which was included in this inspection. [s. 135. (1) (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 and ensuring that every medication incident involving a resident and every adverse drug reaction is:
(b) reported to the resident, the resident's SDM, 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, to be implemented voluntarily.

WN #7: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

In November 2017, the home submitted a written concern and the home's response letter to MOHLTC. The complaint alleged that the resident was on occasion receiving a specified intervention. The family member indicated they had not been notified of a change in care.

The home's investigation record was reviewed. It was noted that the home had been made aware of the above allegation. The homes' written response indicated the home investigated with charge registered staff that implemented the change in July 2017, to ensure the resident's safety. The home provided education to the staff in regards to

informing family members whenever there was a change in care.

The resident's health record was reviewed including progress notes and it was noted that the SDM had been made aware of the change in care during an interaction with the registered staff. It was noted the staff apologized for not notifying the SDM of the change.

The resident's medical record was reviewed with the RAI Co-ordinator. The transfer focus in the plan of care did not include any information related to the change in care. The transfer focus in the subsequent plan of care included information related to the change in care. The RAI Co-ordinator confirmed the resident's care plan was changed.

DOC #100 reviewed the home's investigation record and the resident's health record with inspector #123 and they confirmed that when the resident's plan of care related to specified interventions was changed the resident's SDM was not provided an opportunity to participate fully in the development and implementation of the resident's plan of care.

The home failed to ensure that resident #003's substitute decision-maker, and any other persons designated by the resident or substitute decision-maker, were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Please note: this non-compliance was issued as a result of Complaint log #028816-17, which is included in this inspection. [s. 6. (5)]

Issued on this 25th day of February, 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) :	YULIYA FEDOTOVA (632), DIANNE BARSEVICH (581), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2018_560632_0025
Log No. / No de registre :	028816-17, 010908-18, 011225-18, 011626-18, 012224-18, 013768-18, 018160-18, 025697-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 19, 2019
Licensee / Titulaire de permis :	Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	Chartwell Waterford Long Term Care Residence 2140 Baronwood Drive, OAKVILLE, ON, L6M-4V6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kim Widdicombe

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

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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. 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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 131(2).

Specifically the licensee must:
a) Ensure that specified medications are administered to resident #012 and to all other residents, as prescribed and according to the home's policy and procedure.
b) Ensure that medications are administered to resident #005 and #009 and to all other residents as prescribed and according to the home's Medication Administration policy.
c) The licensee shall develop, complete and document an auditing process to ensure that resident #012 and all other residents are administered medication as prescribed.
d) The licensee shall develop, complete and document an auditing process to ensure that resident #005 and #009 and all other residents are administered medications as prescribed.

Grounds / Motifs :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint (log #025697-18) was received by the Ministry of Health and Long-Term Care (MOHLTC) that resident #005 was administered a specified medication. The medication was not prescribed for the resident. The resident had a specified device in place and no history of using specified medication.

The home's Report and Analysis Form, dated on an identified date in August 2018, was reviewed. It was noted that, on an identified date in August 2018, a

personal support worker reported to the registered staff that resident #005 had received a specified medication. The resident had no medical order for the administration of the medication. The resident's vital signs were assessed. The physician on call was notified and they gave an order for the resident's vital signs to be monitored every shift for an identified period of time. The resident's Substitute Decision Maker (SDM) and the DOC were also notified of the incident. There was no harm to the resident and monitoring/intervention was required. No causes of the incident or contributing factors were identified on the incident report.

The home's incident investigation record was reviewed and indicated information as above.

The resident's health record including the Interdisciplinary Care Conference record, dated in 2018, was reviewed and it was noted the resident had received a medication that had not been prescribed. The home did an investigation but could not determine who administered the specified medication.

The home failed to ensure that no drug was used by or administered to resident #005 in the home unless the drug had been prescribed for the resident.

Please note: this non-compliance was issued as a result of Complaint log #025697-18, which was included in this inspection.

2. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A. A complaint (log #025697-18) was received by the MOHLTC that resident #005 did not receive a specified medication as ordered. The resident was to receive the medication at identified frequency. The resident received an additional doze of the prescribed medication.

The home's investigative records and the health record of resident #005 including the specified Report were reviewed. It was noted that in November 2017, specified medication was administered to resident #005 not as ordered. The resident's SDM, the pharmacy service provider, the attending physician, the DOC and the Medical Director were notified of the incident. There was no harm

to the resident as a result of the incident. Educational support was provided to the staff.

DOC #100 was interviewed and reported information as documented above. They also reported that the physician made a temporary change to the prescribed medication order. DOC #100 confirmed that, on an identified date in November 2017, the medication was not administered to resident #005 in accordance with the directions for use specified by the prescriber.

The home failed to ensure that drugs were administered to resident #005 in accordance with the directions for use specified by the prescriber.

Please note: this non-compliance was issued as a result of Complaint log #025697-18, which was included in this inspection.

B. The home's records for a specified three month period in 2018 were reviewed.

It was noted that, on an identified date in November 2018, staff #128 discovered a medication error involving resident #012. The resident received a specified dose of the medication not as prescribed. The resident/POA, pharmacy service provider, attending physician, DOC, Prescriber and RN EC were notified. The resident was monitored and had no harm as a result of the incident.

The DOC was interviewed and confirmed drugs were not administered to resident #012 in accordance with the directions for use specified by the prescriber.

The home failed to ensure that drugs were administered to resident #012 in accordance with the directions for use specified by the prescriber.

Please note: this non-compliance was issued as a result of Complaint log #025697-18, which was included in this inspection.

C. The home's medication incident records for a specified three month period in 2018, were reviewed.

Resident #009 was ordered specified medication. It was noted that, on an identified date in December 2018, registered staff #131 discovered that the strength of the medication administered to resident #009 was not the same as ordered. As a result, the resident received identified doses of the incorrect strength of the medication. The resident/SDM, physician on-call, DOC #102 and the pharmacy service provider were notified of the incident. The physician was informed and ordered a temporary change in the medication. There was no harm to the resident as a result of the incident.
Registered staff #130 who was involved in the incident, was interviewed and confirmed the information in the home's record.
DOC #100 confirmed drugs were not administered to resident #009 in accordance with the directions for use specified by the prescriber as noted above.

The home failed to ensure that drugs were administered to resident #009 in accordance with the directions for use specified by the prescriber.

Please note: this non-compliance was issued as a result of Complaint log #025697-18, which was included in this inspection.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the resident. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 4 history as despite MOH action (VPC, order), NC continues with original area of NC that included:

- Voluntary Plan of Correction (VPC) issued April 24, 2018 (2018_555506_0013).
(123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 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:

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

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 19th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Yuliya Fedotova

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