Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date May 11, 2022
Inspection Number 2022_1365_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
Long-Term Care Home and City
Chartwell Westmount, Kitchener

Lead Inspector
Kim Byberg (729)

Additional Inspector(s)
Jessica Bertrand (722374)

Inspector Digital Signature
Kim Byberg
2022.05.24 13:10:31 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 21, 22, 26, 27, 2022, offsite: April 25, 2022.

The following intake(s) were inspected:

-Log #004850-22, follow up related to compliance order (CO) #001 of inspection #2022_729615_0002;

-Log #005032-22 (CIS #2880-000008-22) related to a medication incident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 19(1)	2022_729615_0002	001	729

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect

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INSPECTION RESULTS

COMPLIANCE ORDER CO#001 ADMINISTRATION OF DRUGS

NC #01 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 79/10 s. 131 (1)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with O. Reg. 79/10 s. 131 (1)

The licensee shall:

A) Ensure the specified resident is only administered drugs that have been prescribed for the resident. Medication orders for the resident will be processed as per the home's current policy.
B) Educate the remaining two registered staff on the home's medication management policies, including ordering, receiving and processing medication orders; including processing and checking of three-month medication reviews.
C) Keep a record of the education content, who attended, the person providing the education and the date the education was completed in the home.

Grounds

Non-compliance with: O. Reg. 79/10 s. 131 (1)

The licensee has failed to ensure that no drug was used for a resident unless the drug had been prescribed for the resident.

Rationale and Summary
A resident received a specific medication once a day. In their medication review, the physician stopped the medication for the resident.

The medication was not stopped by registered staff and continued to be given to the resident for the next three days.

The home's three-month medication review policy stated that once the physician reviewed and signed the medication review, registered staff would review and process new orders following

the procedure for processing physician orders. The home's pharmacy's ordering and receiving policy stated nurses would transcribe and document completion of the new prescriber order and a second nurse would double check the processing and transcription within 24 hours.

The physician orders to stop the medication were not reviewed and processed by the first registered staff until three days later and were not double checked by the second nurse until seven days later. The Director of Care (DOC) said the registered staff should have reviewed and processed the resident's medication review, with the medication to stop, on the same date the physician made the orders.

The DOC stated they found gaps in the medication transcribing process and therefore, education was given to all registered staff on the new process. Two registered staff had not received the education at the time of inspection.

The specific medication was considered a high alert medication, and when the medication was not stopped by registered staff for three days in a row, there was a risk the resident may have potentially life-threatening adverse reactions. The resident suffered adverse reactions and had an abnormal blood value.

Sources: A resident's progress notes and electronic Medication Administration Record (eMAR), physician medication review, Care Rx Medication Regimen Review dated February 28, 2022, Three Month Medication Review Policy revised December 2017, and Care Rx Ordering and Receiving Medication Policy, revised July 2014, and interviews with registered staff and the DOC.

[722374]

This order must be complied with by June 24, 2022

COMPLIANCE ORDER CO#002 MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #02 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 79/10 s. 135 (1)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with O. Reg. 79/10 s. 135 (1)

The licensee shall:

A) Educate the specified registered staff member on the home's reporting medication incidents policy.

B) Develop and provide education to the specified registered staff member on the risks and monitoring of residents for adverse reactions when receiving the specified medication. The education must also include communicating immediately to the physician when the medication is not given as prescribed.

C) Keep a record of the education content, who attended, the person providing the education and the date the education was completed in the home.

Grounds

Non-compliance with: O. Reg. 79/10 s. 135 (1)

The licensee failed to ensure that medication incidents involving a resident were documented with immediate actions taken and reported to the resident's substitute decision-maker, the director of nursing, the resident's attending physician and the pharmacy service provider.

Rationale and Summary

The physician stopped a medication for a resident and prescribed another medication to start once the resident's lab value was within a specific range.

A) The medication was not stopped by the registered staff on the date it was ordered. A registered staff member indicated that three days later, when they processed the order, they

were aware that the resident received the medication; however, the medication was not stopped, and the resident received the medication that day.

The home's Medications Incidents and Adverse Drug Reaction Policy, stated that for any medication incident, meaning any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication was in control of the health care professional, the registered staff who found the medication incident that involved a resident must:

-Report the incident to the substitute decision maker, medical director, prescribing physician, the director of care, and the pharmacy care provider;

-Complete the medication incident form and fax the completed form to the pharmacy provider.

The registered staff member stated they did not complete a medication incident report or notify the physician. There was no documentation in the clinical record that an error occurred and that the resident continued to receive the medication after it was stopped. Therefore, the physician was unaware of the medication incident until the resident experienced adverse side effects.

The DOC stated the registered staff who discovered the medication incident should have reported the incident and completed the medication incident form on that date.

The medication was classified as a high alert medication, and when the registered staff did not report or document the medication incident, notify the physician, or complete a medication incident report at the time it was discovered, the resident was placed at high risk of not being monitored adequately for potentially life-threatening adverse effects. The resident experienced adverse effects of the medication being given.

Sources: Medications Incidents and Adverse Drug Reaction Policy, revised June 2020, a resident's physician medication review and eMAR, interviews with a registered staff member and the DOC.

B) The home's Medication Incidents and Adverse Drug Reaction Policy stated that if a medication incident was pharmacy based, including dispensing or delivery, registered staff would complete the medication incident report form.

The home's pharmacy processed the order for the new medication with a start date that was before the required lab values were obtained. A registered staff member indicated they identified this error on the date it was processed, and put the medication on hold, but did not complete an incident report.

The DOC stated the registered staff who discovered the medication incident should have completed the medication incident form on that date.

When the registered staff did not complete a medication incident report for the new medication, there was risk that the error would not have been reviewed and analyzed to prevent it from happening again.

Sources: Medications Incidents and Adverse Drug Reaction Policy, revised June 2020, a resident's physician medication review and eMAR, interviews with a registered staff member and the DOC.

[722374]

This order must be complied with by June 24, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the

purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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