Ontario

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

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

Central West District
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Original Public Report

Report Issue Date: May 23, 2023
Inspection Number: 2023-1365-0005
Inspection Type: Critical Incident System
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
Long Term Care Home and City: Chartwell Westmount Long Term Care Residence, Kitchener

Lead Inspector	**Inspector Digital Signature**
Kristen Owen (741123)	Kristen A Owen Digitally signed by Kristen A Owen Date: 2023.05.24 13:29:37 -04'00'

Additional Inspector(s)
Alicia Campbell (741126)
Janet Evans (659)
Mark Molina (000684)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1-5, 2023, and May 9, 2023.

The following intake(s) were inspected:
- Intake 00001747 related to medication management of residents
- Intake 00018152 related to fall prevention and management of a resident

The following intakes were completed in this inspection:
- Intake 00020869, intake 00021030, intake 00084705, and intake 00085762 related to fall prevention and management of residents

NOTE: A Written Notification related to O. Reg. 246/22 s. 140 (2) was identified in this inspection and has been issued in a concurrent inspection, #2023_1365_0007, dated May 23, 2023.
A Written Notification related to O. Reg. 246/22 s. 54 (1) was identified in this inspection and has been issued in a concurrent inspection, #2023_1365_0006, dated May 23, 2023.

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

Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure resident #003 was protected from neglect by staff in the home.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents."

Rationale and Summary
On an identified date, resident #003 had a fall. In the post-fall assessment, it was identified that the resident required a new intervention to prevent further falls. The intervention was not immediately implemented, and the staff member who was responsible for monitoring the resident while waiting for the intervention to be implemented, did not continue to monitor the resident, which resulted in the resident having another fall and sustaining injuries.

This inaction, specifically staff failing to implement the intervention and the staff member not providing continuous monitoring, jeopardized the resident's health as they had another fall and sustained injuries.

Sources: Resident #003's clinical health records; the home's critical incident investigation notes; interviews with staff

[000684]

WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with their written policies and protocols that were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of drugs used in the home when the electronic Medication Administration Record (eMAR) was not signed after resident #003 was administered a medication.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure written policies and protocols were developed for the medication management system, and they must be complied with.

Specifically, staff did not comply with the policy "Medication Administration Policy", last revised December 2017, which included that a medication administration record (MAR) should be signed by the person who gave the medication immediately following the medication administration.

Rationale and Summary
On an identified date, resident #003 had complaints of pain. It was documented in the resident's clinical health records that an RN provided the resident with as needed (PRN) pain medication. The medication administration was not signed off on the electronic medication administration record (eMAR). As per the home's medication administration policy, a MAR should be signed off immediately following medication administration by the person who gave the medication. Staff confirmed that the eMAR was not signed off by the RN.

By not signing off the eMAR immediately following medication administration as per policy, there was a risk for a medication incident.

Sources: Interviews with staff; resident #003's clinical health records; Medication Administration Policy, Policy No: LTC-CA-WQ-200-06-01, last revised December 2017.

[000684]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication

cart when an RPN did not store a controlled substance as required.

Rationale and Summary
During the inspection, an RPN was observed signing the controlled substances book and administering a controlled substance without unlocking the double locked box to retrieve the controlled substance.

The RPN said they had taken the controlled substance out of the locked box at the start of the medication pass and stored it in the resident's medication box, within the first lock of the medication cart, until they administered it. Between taking the controlled substance out of the locked box and administering it, the RPN provided six other residents with their scheduled medications. The RPN said that controlled substances were to be stored in a double locked area of the medication cart.

Incorrect storage of the controlled substance caused a potential risk for the controlled substance to be more easily accessible to individuals who could misuse them and potential for a medication error.

Sources: Observation of medication pass; Interviews with staff; Narcotics Policy LTC-CA-WQ-200-06-14.

[741126]