Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2018	2018_654618_0026	026451-18	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell White Eagle Long Term Care Residence
138 Dowling Avenue TORONTO ON M6K 3A6

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

CECILIA FULTON (618), JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 1, 2, 3, 4, 5, 2018.

The following Critical Incident Intake inspection log, related to falls was inspected concurrently with this RQI: Log # 005457-18, CIR #2583-000004-18.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Residents' Council chair, Program Support Services Manager, Residents and Family members.

During the course of the inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, observed medication administration, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

During stage two of the RQI resident #002 triggered for catheter use from the staff interview.

Review of the progress notes indicated that resident #002 returned from the hospital on an identified date in 2018, with an identified diagnosis and identified prescribed interventions.

Review of resident #002's clinical records identified a required scheduled care need at a particular frequency for the above mentioned, prescribed intervention. Review of the Electronic Treatment Record (e-tar) identified the next scheduled date that the care was to be provided. That scheduled provision of this care was not signed off as having been completed.

In an interview, RN #107 indicated that they had provided resident #002 with the care on the scheduled date in 2018, with the assistance of RN #108, but had not documented it on the eTAR. This was confirmed by the ADOC. [s. 6. (9) 1.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent had received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

During stage two of the RQI resident #002 triggered for an identified continence issue.

According to the minimum data set (MDS) assessment resident #002's continence level had changed during an identified assessment period in 2018.

Review of the progress notes indicated that resident #002 returned from the hospital on an identified date in 2018, with an identified diagnosis and identified prescribed interventions.

Review of the residents health record failed to include a completed continence assessment for the identified change in continence status.

In separate interviews, RN #103 and RN #107 indicated that the continence assessment was to be completed, using the home's clinically appropriate assessment instrument on admission and whenever there was a change in a resident's continence status. They acknowledged that a continence assessment was not completed when resident #002's continence status changed. [s. 51. (2) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The Licensee has failed to ensure that no more than a three-month supply of medication was kept in the home at any time.

This inspection was triggered by a stage two observation of one of the homes medication carts on an identified date in 2018. During this observation, the inspector identified bottles of medications that prompted closer observation, due to the size of the bottles.

Interview with RPN #101, revealed that the medications had been supplied by the resident's family.

There were four, family supplied medications observed for resident #006, and all of the identified medications were in a supply greater than three months.

Interview with RPN #101 revealed that when families request to supply medications, the physician is notified and prescribes the medication and the medication is added to the Electronic Medication Record (E-Mar).

Inspector review of resident #006's records confirmed that all family supplied medications had been prescribed by a physician, transcribed on to the E-Mar, and had been administered as ordered.

Interview with the ADOC revealed that there is a policy regarding natural health products, however it does not address issues related to supply. They confirmed the supply of the above noted medications exceeded a three month supply. [s. 124.]

Issued on this 22nd day of October, 2018

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

Original report signed by the inspector.