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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2018	2018_486653_0028	027802-18	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 Woodhaven Long Term Care Residence
380 Church Street MARKHAM ON L6B 1E1

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

ROMELA VILLASPIR (653)

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): October 31, and November 1, 2018.

During the course of the inspection, Complaint Log #027802-18 related to incorrect administration of medication, had been inspected.

During the course of the inspection, the inspector observed the provision of care to resident #001, reviewed the home's staffing schedule, clinical health records, investigation notes, and the resident's personal video camera footage provided by the complainant.

During the course of the inspection, the inspector(s) spoke with the Registered Practical Nurses (RPNs), Registered Nurses (RNs), RPN Student, Agency RPN (ARPN), Registered Dietitian (RD), Acting Director of Care (aDOC), Director of Care (DOC), Consultant Resident Care and Services Nursing (CRCSN), and the Administrator.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to the resident.

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONline had received a complaint related to incorrect administration of medication to the resident that resulted in an identified medical condition.

A review of resident #001’s written plan of care indicated they had an identified medical condition, and they required an identified food and fluid intervention. The written plan of care directed the staff to provide an identified type of assistance for eating and drinking.

A telephone interview with Agency Registered Practical Nurse (ARPN) #102 indicated they had worked at the home on the identified date and shift, and they were the assigned nurse in the home area where resident #001 resided. The ARPN further indicated they had a student trainee with them at that time, and they started the medications together. When it was time for resident #001’s medications, ARPN #102 stated they checked the electronic Medication Administration Record (eMAR) and had seen the instructions on how to administer the resident's medications.

A telephone interview with RPN Student #103 indicated they were with ARPN #102 on the identified date and shift, and confirmed they were with the ARPN when the ARPN prepared resident #001’s medications. RPN Student #103 stated the ARPN checked all the medications including a specified medication against the eMAR, prepared the medications accordingly, and under the specified medication the RPN read an identified

instruction. RPN Student #103 further indicated the eMAR did not indicate under the specified medication that it had to be mixed with an identified food item.

A review of resident #001's electronic health record profile revealed on an identified date, a special instruction for the administration of the specified medication had been entered under the special instructions section, which were autopopulated to the eMAR screen. The special instruction directed the registered staff to prepare the specified medication with an identified food item. On an identified date and time, Inspector #653 and RPN #100 reviewed resident #001's eMAR screen from the date and time of the incident, and the RPN noted that the special instructions were reflected on the eMAR screen, in an identified area and just above the list of medications to be administered. However, when RPN #100 clicked on the specified medication box, it indicated a different instruction for administration. RPN #100 acknowledged that the instructions for the administration of the specified medication were not consistent, and that the written plan of care did not provide clear directions.

During an interview, the Acting Director of Care (aDOC) and Inspector #653 reviewed resident #001's eMAR and electronic health record profile, and the aDOC acknowledged that resident #001's written plan of care did not provide clear directions to staff and others who provided direct care to the resident, and that the instructions should have been the same on the eMAR box for the specified medication and under the special instructions section.

The licensee had failed to ensure that resident #001's written plan of care sets out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee had failed to ensure that the care set out in the plan of care had been provided to the resident as specified in the plan.

The MOHLTC ACTIONline had received a complaint related to incorrect administration of medication to the resident that resulted in an identified medical condition.

A review of resident #001's written plan of care indicated they had an identified medical condition, and they required an identified food and fluid intervention. The written plan of care directed the staff to provide an identified type of assistance for eating and drinking.

On an identified date, an identified person provided the inspector a copy of a number of video clips with audio sound from the date and time of the incident that had been

captured from the video camera situated in the resident's room. The identified person confirmed that resident #001, ARPN #102, the Director of Care (DOC), and themselves were identified in the video.

A review of the video clips revealed ARPN #102 did not provide care to resident #001 as specified in their plan of care.

A telephone interview with RPN Student #103 indicated they were with ARPN #102 on the identified date and shift, and confirmed they were with the ARPN when the ARPN prepared resident #001's medications. RPN Student #103 indicated the ARPN did not prepare a specified medication as per the resident's plan of care.

A telephone interview with ARPN #102 indicated they had worked at the home on the identified date and shift, and they were the assigned nurse in the home area where resident #001 resided. The ARPN further indicated they had a student trainee with them at that time, and they started the medications together. When it was time for resident #001's medications, ARPN #102 stated they checked the eMAR and had seen the instructions on how to administer the resident's medications including the specified medication. The RPN acknowledged that the specified medication was not consistent with how it was specified to be administered as per resident #001's plan of care, when it had been administered to the resident.

A telephone interview with the DOC indicated on the date and time of the incident, an identified person had called them to the resident's room and reported that ARPN incorrectly administered a specified medication to the resident. The DOC attended to the resident and noted no signs of distress.

An interview with RPN #100, indicated they were the regular RPN in the identified home area. When asked by the inspector how the specified medication was administered, RPN #100 indicated that in order to ensure resident #001 received the specified medication as per their plan of care, the specified medication was mixed in an identified food item and given to the resident at an identified meal service.

During an interview, the Consultant Resident Care and Services Nursing (CRCSN) and Inspector #653 watched the first three video clips together, and the CRCSN acknowledged that care had not been provided to resident #001 as specified in the plan as observed in the video clips. The CRCSN further acknowledged that not providing care as specified in the plan had placed the resident at risk for an identified medical condition.

The licensee had failed to ensure that the care set out in the plan of care had been provided to resident #001 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 30th day of November, 2018

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

Original report signed by the inspector.

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) : ROMELA VILLASPIR (653)

Inspection No. / No de l'inspection : 2018_486653_0028

Log No. / No de registre : 027802-18

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Nov 30, 2018

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 Woodhaven Long Term Care Residence
380 Church Street, MARKHAM, ON, L6B-1E1

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jason Gay

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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:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan to ensure the following:

1. Care is provided to resident #001 as specified in their plan of care, as it relates to their identified medical condition.

2. An auditing system is in place to ensure care is provided to resident #001 as specified in their plan of care, as it relates to their identified medical condition.

3. The above mentioned documentation shall be available to the inspector upon request.

The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca referencing report #2018_486653_0028 to Romela Villaspir, LTC Homes Inspector, MOHLTC, by December 21, 2018, and implemented by January 11, 2019.

Grounds / Motifs :

1. The licensee had failed to ensure that the care set out in the plan of care had been provided to the resident as specified in the plan.

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONline had received a complaint related to incorrect administration of medication to the resident that resulted in an identified medical condition.

A review of resident #001's written plan of care indicated they had an identified medical condition, and they required an identified food and fluid intervention. The written plan of care directed the staff to provide an identified type of assistance for eating and drinking.

On an identified date, an identified person provided the inspector a copy of a number of video clips with audio sound from the date and time of the incident that had been captured from the video camera situated in the resident's room. The identified person confirmed that resident #001, Agency Registered Practical Nurse (ARPN) #102, the Director of Care (DOC), and themselves were identified in the video.

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A telephone interview with the DOC indicated on the date and time of the incident, an identified person had called them to the resident's room and reported that ARPN incorrectly administered a specified medication to the resident. The DOC attended to the resident and noted no signs of distress.

An interview with RPN #100, indicated they were the regular RPN in the identified home area. When asked by the inspector how the specified medication was administered, RPN #100 indicated that in order to ensure resident #001 received the specified medication as per their plan of care, the specified medication was mixed in an identified food item and given to the resident at an identified meal service.

During an interview, the Consultant Resident Care and Services Nursing (CRCSN) and Inspector #653 watched the first three video clips together, and the CRCSN acknowledged that care had not been provided to resident #001 as specified in the plan as observed in the video clips. The CRCSN further acknowledged that not providing care as specified in the plan had placed the resident at risk for an identified medical condition.

The licensee had failed to ensure that the care set out in the plan of care had been provided to resident #001 as specified in the plan.

The severity of this issue was determined to be a level 3 as there was actual risk to the resident. The scope of the issue was a level 1 as it related to one resident. The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:
-Voluntary Plan of Correction issued June 23, 2016 (#2016_405189_0003);
-Voluntary Plan of Correction issued June 27, 2017 (#2017_632502_0007);
-Compliance Order issued January 17, 2018 (#2017_530673_0015);
-Voluntary Plan of Correction issued October 1, 2018 (#2018_718604_0009).
(653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 11, 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 30th day of November, 2018

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Romela Villaspir

Service Area Office / Bureau régional de services : Central East Service Area Office