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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 23, 2023	
Inspection Number: 2023-1365-0007	
Inspection Type: Complaint and 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 Kristen Owen (741123)	**Inspector Digital Signature**
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 intakes were completed in this Critical Incident (CI) inspection:

- Intake 00020751 and intake 00085038 related to alleged neglect of a resident.

The following intakes were completed in this complaint inspection:

- Intake 00020849 and intake 00085030 regarding the plan of care for a resident.

NOTE: A Written Notification related to O. Reg 246/22, s. 140(2) was identified in a concurrent inspection #2023_1365_0005 (Intake: 00001747) and issued in this report.

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

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to residents #001, #005, #006 and #007 in accordance with the directions for use specified by the prescriber when resident #001 received their hydration intervention at a flow rate higher than what was prescribed by the Physician, and when residents #005, #006 and #007 did not receive their medications within the correct time frame.

Rationale and Summary
1) The Physician ordered a hydration intervention to resident #001 at a specified rate per hour. When resident #001's Substitute Decision-Maker was visiting, they informed staff that the rate of the hydration intervention was higher than what was ordered.

Staff confirmed the hydration intervention was not administered as prescribed.

By not administering the hydration intervention in accordance with the directions for use by the prescriber, resident #001 was at risk for fluid overload.

Sources: Resident #001’s clinical health records; interviews with staff

[741123]

2) During a medication audit, Registered Nurse (RN) #117 discovered medication errors made by RN #119 that affected 16 residents.

A) Resident #005’s 1200 hours (hrs) medications were missing from the medication cart, and it was more than an hour ahead of the scheduled administration time. RN #119 said they gave the resident their medications early.

B) Resident #007’s 1200 hrs medications were missing from the medication cart, and it was more than an hour ahead of the scheduled administration time. RN #119 said they gave the resident their medications early.

C) Resident #006’s 0800 hrs medications, that included a controlled substance, were signed as

administered, but had not been administered, and it was over one hour past the scheduled administration time. RN #117 notified RN #119 to administer the medications to the resident.

RN #117 stated that providing the residents with their medications over one hour early or over one hour late is a medication error.

Staff acknowledged that resident #005's, #006's and #007's medications had not been administered in accordance with the directions for use specified by the prescriber.

When the nurse administered medication incorrectly to 16 residents this could have negatively impacted the residents health.

Sources: Resident #005's clinical health records; Resident #006's clinical health records; Resident #007's clinical health records; the home's investigation package; interviews with staff

[741126]