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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 9, 2014	2014_232112_0057	004150-14 & 000811-14	Complaint

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET, LONDON, ON, N5V-3R3

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

KENSINGTON VILLAGE
1340 HURON STREET, LONDON, ON, N5V-3R3

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

CAROLE ALEXANDER (112)

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): September 02, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care, a Registered Nurse, a Personal Support Worker and a Resident.

During the course of the inspection, the inspector(s) reviewed 2 clinical records, a critical incident, the home's policy and procedure for medication reconciliation, relevant falls assessments and specialty referral information.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that the home's policy for medication reconciliation was complied following a resident's readmission to the home from hospital.
The home's policy entitled "Medication Reconciliation" "Section 4 Policy 4-3" states that the policy is to be used for all residents returning to the facility following hospitalization and that the "best possible medication history includes the review of all previous medications and information source ie. family" be utilized.
A resident was readmitted to the home following a hospital admission. A Registered Staff member transcribed the resident's medication using only the resident's discharge summary from the hospital which resulted in the dosage of one medication being incorrect.
The Registered staff member did not use the resident's previous medication history and the resident's family was not consulted.

This was confirmed by a Registered Nurse and the Director of Care [s. 8. (1) (b)]

Issued on this 9th day of September, 2014

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