Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 4, 2021	2021_750539_0015	010585-21, 010623-21, 011379-21, 011412-21	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Sara Vista
27 Simcoe Street Elmvale ON L0L 1P0

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

VALERIE GOLDRUP (539)

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 21-24, 2021.

The following intakes were completed in this Complaint inspection:

Log #s 011412-21, 011379-21, 010623-21, and 010585-21 were related to the provision of resident care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED) / Director of Care (DOC), the Assistant Director of Care, the Recreation Manager, the Maintenance Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), and residents.

During the course of the inspection, the inspector observed resident and staff interactions, and the home's infection prevention and control practices. The inspector also reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Infection Prevention and Control
Medication
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident unless the drug was prescribed for the resident.

A registered staff administered the wrong medication to a resident. The resident received a controlled substance at a higher dose than was prescribed.

As a result of the resident not receiving their medication as prescribed, the resident was placed at risk for harm.

Source: Resident progress notes, the Medication Incident Report, interviews including the registered staff

Additional Required Actions:

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was treated with courtesy and respect and in a way that fully recognized the resident’s individuality and respected the resident’s dignity during their toileting routine.

A resident asked for Personal Support Worker (PSW) assistance with their toileting routine.

The PSW's comments and demeanour when the resident asked them for assistance to be toileted made the resident feel like the PSW was inconvenienced.

The resident was not treated with courtesy and respect and in a way that fully recognized the resident’s individuality and respected the resident’s dignity during their toileting routine. This caused the resident to be upset by how the PSW provided them care.

Source: resident's progress notes, interviews including registered staff and the Executive Director

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Issued on this 6th day of October, 2021

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

Original report signed by the inspector.