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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2018	2018_674610_0017	006138-18, 006139-18, 006140-18, 006141-18, 006142-18	Follow up

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

Elmwood Place
46 Elmwood Place West LONDON ON N6J 1J2

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

NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 28, October 1, 2, ,3, 4, 5, 9, 10, 11, 12, and 15, 2018

The following intakes were inspected concurrently while in the home completing the follow up orders:

Log #019185-17 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.

Log #022549-17 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #028727-17 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #000866-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #007282-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #008590-18 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #009140-18 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #009751-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #010716-18 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #011230-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #017557-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #020851-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #024530-18 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #025256-18 Critical Incident #2018_674610_0016 related to alleged resident to resident abuse.
Log #027282-18 Critical Incident #2018_674610_0016 related to alleged staff to resident abuse.
Log #026016-17 Critical Incident #2018_674610_0016 related to falls.
Log #007497-18 Critical Incident #2018_674610_0016 related to infection prevention and Control.
Log #026877-18 Critical Incident #2018_674610_0016 related to safe and secure missing resident.

Log# 020270-18 Inspection #2018_674610_0018 Complaint Info-line #58692 IL-58805 related to care concerns.

Log #006139-18, related to a follow up to Compliance Order #001 issued in

Resident Quality Inspection #2017_508137_0022 regarding O. Reg. 79/10, s.8.(3) 24/7 Registered Nurse coverage in the home.
Log #006140-18, 006141-18, 006142-18, 006138-18 related to a follow-up to Compliance Order #002, #003, #004, #005 issued in Resident Quality Inspection #2017_508137_0022 regarding O. Reg. 79/10, related to medication management.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Co-Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Behavioural Supports Ontario Personal Support
Worker, Dietary Aides, Regional Manager, Clinical Consultant Pharmacist, Recreational Therapist Manager, Social Worker, family members and residents.

The inspector(s) also made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meals, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 116. (1)	CO #002	2017_508137_0022	610
O.Reg 79/10 s. 129. (1)	CO #003	2017_508137_0022	610
O.Reg 79/10 s. 133.	CO #004	2017_508137_0022	610
O.Reg 79/10 s. 135.	CO #005	2017_508137_0022	610
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2017_508137_0022	610

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. 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).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A specific resident's, medication incident report showed the type of incident was wrong medication that was administered and had not been prescribed for that resident.

Further review of the medication incident report showed that a nurse administered the medication that had been discontinued and had not been removed from the medication cart.

The homes policy Medication Administration showed that a "Medication refused, discontinued, or not administered will be disposed of according to the jurisdictional requirements"

The medication incident report identified the root cause of the incident was related to "performance deficit".

The DOC said that the expectation was that all discontinued medication would be removed for drug destruction and that medication would only be provided to the resident if the medication had been ordered and prescribed. [s. 131. (1)]

2. The licensee has failed ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Medication incident report showed that a specific resident did not have a specific medication administered as prescribed as the medication had been discontinued without a physician order.

The Supplemental Medication Incident Reporting Form showed that the contributing factors was related to a technology issue.
The omission of the medication errors was not noted until five days after the medication had been discontinued.

The homes policy Care Medication Administration: Each home will ensure they have accurate acquisition, receipt, dispensing, storage, administration, destruction, and disposal of all the drugs in the home to provide residents with safe and timely medication

and ensure the best possible outcome for residents.

The licensee has failed ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 was used by or administered to a resident in the home unless the drug has been prescribed for the resident and ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 25th day of October, 2018

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

Original report signed by the inspector.