



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

**Health System Accountability and Performance Division
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**Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

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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
Nov 29, 2013	2013_303563_0005	L-000937-13	Critical Incident System

Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North, P.O. Box 460, Tavistock, ON, N0B-2R0

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

PEOPLECARE OAKCROSSING LONDON
1242 Oakcrossing Road, LONDON, ON, N6H-0G2

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

MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 26, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Pharmacist, and registered staff.

During the course of the inspection, the inspector(s) made observations, reviewed health records, policies and other relevant documentation.

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



Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 107. Reports re critical incidents



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Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to make a report in writing to the Director within 10 days of becoming aware of an incident setting out the following with respect to the incident; the analysis and follow-up action including the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

Director of Care (DOC) confirmed she did not follow up with the Director through amendment of the Critical Incident Report the immediate actions and long-term actions taken to prevent a missing or unaccounted for controlled substance. [s. 107. (4) 4.]



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WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)

Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure the following information is recorded in respect of every drug that is ordered and received in the home: the date the drug is received in the home and the signature of the person acknowledging receipt of the drug on behalf of the home.
 - a) Director of Care (DOC) confirmed missing registered staff written signature on receipt of Hydromorphone 2mg/ml Ampules on home record,
 - b) Medication Portal - Receiving Details report shows registered staff did not scan receipt of Hydromorphone 2mg/ml Ampules for two shipments of 20 ampules, and
 - c) Pharmacist confirmed Hydromorphone was scanned as shipped from the pharmacy to the home. The Licensee did not confirm receipt of the drug by way of scanning bar codes to acknowledge receipt of drug. [s. 133.]



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Issued on this 29th day of November, 2013

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

Melanie Northey