

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	•	Type of Inspection / Genre d'inspection
Aug 29, 2014	2014_243504_0025	L-000473-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.

55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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 DEIRDRE BOYLE (504)

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): July 21, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care and one resident.

During the course of the inspection, the inspector(s) reviewed the Critical Incident System report, the homes' Prevention of Abuse and Neglect policies and the clinical records of two residents.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation



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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES				
Legend	Legendé			
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

- s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
- (a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
- (b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
- (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).



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

Findings/Faits saillants:

1. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

In April, 2014, resident #002 was involved in an altercation with resident #001. Resident #002 sustained an injury.

An entry into the Progress Notes for resident #002 revealed the plan to continue to monitor the injury.

Through review of the resident's health care records it was revealed that the resident had not been reassessed since the date of the incident. This was confirmed by the Director of Care.

Review of the Care Plan for resident #002 revealed that the care plan had not been reviewed and revised to include the plan to monitor resident's injury. This was confirmed by the Director of Care who also confirmed that it is the home's expectation that when the resident's care needs changed that the plan of care should be reviewed and revised. [s. 6. (10) (b)]

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 the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.



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

Issued on this 29th day of August, 2014

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